Rural EMS Position Paper

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In order to assist the Office of EMS and the Commissioner of Health in evaluating applications for waiver of the requirement for an EMT to be in an ambulance where ALS care is provided, the Medical Direction committee has created the following document to provide additional insight into the pertinent issues.

Our sense is that this exemption should generally be limited to rural EMS agencies. Defining a rural EMS agency is difficult, but characteristics may include: low call volume, or volume high relative to personnel available, predominantly volunteer staffing, sparsely populated service area, long transport times to hospitals, and lack of additional resources or timely, reliable mutual aid assistance. Supporting information addressing which of these characteristics apply to the agency requesting the exemption should be included in the waiver application.

Adequate staffing of EMS agencies in underserved areas can be a critical determinant of response time and level of care provided. Many rural agencies function with a completely volunteer staff, while others are using various arrangements of a mostly volunteer staff supplemented by a paid medic on duty at the station, this often being done during weekday hours only.

Dispatching and staffing of volunteer personnel response for a 911 EMS call is done in one of two general ways. Some agencies have "on call" schedules for their personnel, which obligate pre-assigned crews from the agency's rooster to be available by 911-dispatched radio or pager and to respond to any call during their "on call' period. Other agencies "tone out" all personnel for a call and utilize whichever personnel are able to respond.

Some agencies use a combination of these two methods. Depending upon the "mix" of the various EMS certifications on an agency's roster, and upon the time of day and usually unpredictable availability of the agency's personnel, the response might be rapid and appropriately staffed or might be delayed and/or less than adequately staffed. An example of this would be a 911 EMS call requiring Advanced Life Support (ALS) for which only a Basic Life Support response was effected because of the unavailability of ALS personnel. Even when those agencies employing a paid medic/s have a call when the medic is on duty, the agency often, if not most times, still needs to request its volunteer personnel to assist with a call.

It is important to keep in mind that the above description of rural EMS agency staffing and response methods are just for a single or a "first" EMS call for one patient. Multiple

patient calls, typically involving motor vehicle accidents, and additional simultaneous "second" or even "third" calls often if not always put an immediate strain on an agency's staffing capacity. Responding to such a second and/or third call might have to be accomplished with a bare minimum staff per ambulance, versus no response at all by that agency or a dangerously (and equally unpredictable) mutual aid response by a nearby agency.

As is the case with all of Virginia's EMS Regulations, those regulations regarding ambulance staffing are focused on providing and maintaining patient safety and quality of care. For instance, the regulations require that an ALS ambulance respond with a minimum of two personnel, one of which obviously must be certified at the EMT-CT or EMT-P level, while the other must be certified at least at the EME-B level. This is a very reasonable requirement and in fact it could be argued that a third person might be required as a driver allowing the EMT-B to be in the back with the ALS person throughout the transport. However, the reality in some rural EMS agencies, given the staffing and response methods discussed above along with their attendant problems, is that dispatching an ambulance/s to "second", "third", or even multiple- patient "first" ALS calls would not occur in a timely manner or at all if those agencies were strictly held to regulation staffing requirements. This has resulted in a number of rural EMS agencies requesting exemptions to the otherwise reasonable staffing regulations, thereby permitting them to respond to ALS level calls with the necessary EMT-CT or EMT-P and a driver who might be a non-EMT staff member, firefighter, or law officer. The reasoning behind this type of exemption request is that a rapid response by an ALS level EMS person, along with the proper equipment carried on an ALS ambulance, further assisted by a non-EMT driver who probably is CPR certified, could clearly result in life saving interventions being employed in a timely manner. This would be in contrast to those same two personnel waiting on the ramp at the station unable to respond because of the lack of an EMT-B or an unacceptably delayed response by a mutual request, either of which might result in unnecessary patient harm or death.